

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039398**

**FILED VS NOV 17 1959**

73

Primary Registration District No. **3015**

Registrar's No. **95**

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CLINTON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAMERON</b> Length of stay in 1b <b>LIFE</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CAMERON HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLINTON</b> c. CITY OR TOWN <b>CAMERON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>302 PINE ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>LENA MADDEN KLOPPER</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Nov. 11. 1959.</b>							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>MAR. 3. 1874.</b>		<b>9. AGE (last birthday)</b> <b>85</b>		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HR.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Horsekeeper</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>CLINTON Co. MO</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			
<b>13a. FATHER'S NAME</b> <b>JAMES T. MADDEN</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>NANCY HARDWICK</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>FRANK Deceased.</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>George Klopper</b> Address <b>Memphis Tenn.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (a) <b>Generalized debility and indigestion</b>										<b>20 days</b>	
DUE TO (b) <b>Generalized metastasis from</b>										<b>6 wks</b>	
DUE TO (c) <b>Adeno carcinoma of stomach</b>										<b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>					
<b>21. I attended the deceased from</b> <b>7/27/59</b> to <b>11/11/59</b> and last saw her/him alive on <b>11/11/59</b> Death occurred at <b>12:05 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> <b>E. S. Brown</b> (Degree or title)						<b>22b. ADDRESS</b> <b>Cameron Mo</b>				<b>22c. DATE SIGNED</b> <b>11/12/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE</b> <b>Nov. 13. 59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>EVERGREEN Cemetery</b>				<b>23d. LOCATION</b> (City, town, or county) (State) <b>CAMERON Mo</b>			
<b>24. FUNERAL DIRECTOR</b> <b>De Moss ERANK</b> ADDRESS <b>CAMERON Mo Nov 13-59</b>						<b>25. DATE RECD. BY LOCAL REG.</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Francis D Crawford</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NS NOV 20 1959

FEB 9 1960

JAN 13 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Thomas C. ...*

Licensed Embalmer No. 2533  
P. O. Address Cameroon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.